Cayce
DERMATOLOGY CENTER

Village of Cherry Hill
2011 Corona Road ~ Suite 207 ~
Columbia, MO 65203
573.234.1000 *phone*
573.234.1771 *fax*
www.columbiaderm.com

Please Complete Both Sides

Your Name

Past Medical History

(Please mark all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Reflux)
- ☐ *None of the above*
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other_____
- ☐ *None of the above*

Past Surgical History

(Please mark all that apply)

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy [Left / Right / Both]
- ☐ Breast: Mastectomy [Left / Right / Both]
- ☐ Colon: (Colectomy) Colon Cancer Resection
- ☐ Colon: (Colectomy) Diverticulitis
- ☐ Colon: Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biologic Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip [Left / Right / Both]
- ☐ Joint Replacement: Knee [Left / Right / Both]
- ☐ Kidney: Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: (Nephrectomy): Removal of Kidneys
- ☐ *None of the above*
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries: (Oophorectomy): Endometriosis
- ☐ Ovaries: (Oophorectomy): Ovarian Cancer
- ☐ Ovaries: (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: (Prostatectomy): Prostate Biopsy
- ☐ Prostate: (Prostatectomy): Prostate Cancer
- ☐ Prostate: (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen: (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus: (Hysterectomy): Fibroids
- ☐ Uterus: (Hysterectomy): Uterine Cancer
- ☐ Uterus: (Hysterectomy): Cervical Cancer
- ☐ *None of the above / Other* _____

Turn over to complete back side

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Skin Disease History

(Please mark all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ *None of the above*
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ Other _____
- ☐ *None of the above*

Do you use sunscreen? ☐ Yes ☐ No

If yes, what SPF do you use? _____

Do you tan in a Tanning Salon? ☐ Yes ☐ No

Do you have a family history of Melanoma?

☐ Yes ☐ No

If yes, which relative? _____

Medications

(Please enter all current medication without dosages)

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

(Please include all medication allergies)

_____ _____

_____ _____

Social History

(Mark all that apply)

Smoking Status

☐ Daily ☐ Occasionally ☐ Former Smoker ☐ Never

Sexual Activity

☐ Not active ☐ Active with one partner
☐ Active with more than one partner
☐ Active with partner of the same sex

Drug Use

☐ None ☐ Uses Drugs ☐ Uses IV Drugs

Alcohol Use

☐ None ☐ Less than 1 drink/day ☐ 1-2 drinks/day
☐ 1-2 drinks/day ☐ 3 or more/day

I feel safe at home ☐ Yes ☐ No

Exercise

☐ Daily ☐ Weekly ☐ Monthly

Caffeine Use

☐ Daily ☐ Weekly ☐ Monthly

Occupation & Workplace: _____

Turn Over